Duty to Protect: General Principles and Practical Advice

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Disclosures/Conflicts of Interest

- The presenter does not have any conflicts of interest to disclose.
- NOTE: The information presented in this webinar is not intended to provide legal advice or to substitute for the advice of an attorney, but rather to provide information about considerations when dealing with records and requests for information.

Learning Objectives

1. Explain mandated and permissive versions of the legal duty to protect others from a dangerous patient.

2. Compare the duty to warn and the duty to protect.

3. Identify steps that minimize risks to the clinician when approaching duty-to-protect situations.

The *Tarasoff* Case

CHARACTERS

Defendant	=	Lawrence Moore, Ph.D. & UCLA
Patient	=	Prosenjit Poddar
Plaintiff/Victim	=	Tanya Tarasoff

FACT PATTERN

- Poddar falls in love with Tarasoff. He is rebuffed, becomes depressed and irrational
- Poddar voluntarily begins psychotherapy with Dr. Moore
- Poddar expresses in psychotherapy the intent to kill Tarasoff

The *Tarasoff* Case (Cont'd)

CHARACTERS

Defendant	**=**	**Lawrence Moore, Ph.D. & UCLA**
Patient	**=**	**Prosenjit Poddar**
Plaintiff/Victim	**=**	**Tanya Tarasoff**

- **Dr. Moore notifies campus police to bring Poddar to hospital for psychiatric commitment (Dr. Moore does not warn Tarasoff)**
- **Campus police interview but release Poddar because he appears rational**
- **Poddar kills Tarasoff**
- **Poddar convicted of murder (conviction overturned on technicality—moves to India)**
- **Tarasoff's family sues Dr. Moore and UCLA for failure to warn them about Poddar**

The *Tarasoff* Case (Cont'd)

California Supreme Court hears the case in 1976:

Upholds Dr. Moore's professional malpractice conviction for failure to protect Tanya Tarasoff,

and

Creates, in California, a duty for mental-health professionals who treat outpatients to warn/protect 3rd parties under certain circumstances.

Applying the Professional Malpractice Analysis to *Tarasoff*

Duty — Dr. Moore had a duty → The court held: "When a therapist determines, or pursuant to the standards of his profession, should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.

Breach — Dr. Moore breached his duty → The court held: "The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police or to take whatever other steps are reasonably necessary under the circumstances". Dr. Moore failed to do so.

Cause — Dr. Moore's breach of his duty foreseeably and directly caused Tanya Tarasoff's death

Harm — Tanya Tarasoff lost her life and her family is entitled to money damages

But, the DTP Also Creates Another Risk

- 3rd parties injured by dangerous pt will sue MHP for failing to restrain the dangerous patient (*Tarasoff* case)

- Patient will sue MHP for breach of confidentiality and subsequent harm to the patient

Legal Basis for DTP Laws

In criminal law, as well as tort law, there is no general duty to rescue people from trouble, much less prevent it. Thus, it is usually not a crime to watch a person drown, or to fail to alert a potential victim that someone is intent on killing them.

Tarasoff stands for the general proposition that when a special relationship exists, a person has a duty to take reasonable steps to prevent the misconduct of that person if that misconduct will likely inflict harm to a third party.

Impact of DTP Laws

- Greater initiation of questioning by therapists about dangerousness
- Decreased patient openness about dangerousness
- Some therapists avoid asking about dangerousness
- Therapists more careful about screening out potentially violent patients
- It remains unclear whether DTP laws have had any impact on decreasing patient's inflicting harm on 3rd parties

Key Elements of a DTP Law

- Nature and scope of the duty
- Mandatory vs. permissive DTP laws
- Who must act to protect
- Ways of discharging the duty
- Presence/absence of immunity

Key Elements of a DTP Law

Today, the duty to protect most commonly arises when:

- a duty is owed to the known or knowable victim
- a patient threatens an identifiable victim;
- The therapist takes appropriate actions, which may include:
  - initiating commitment proceedings (voluntary or involuntary),
  - informing the authorities or others,
  - and/or warning the intended victim.

Mandatory/Permissive/No Duty DTP Laws

Duty States

The general formula in these jurisdictions is that a psychotherapist has a duty to warn either the victim or law enforcement after a patient makes an explicit and specific threat of physical harm.

One important variation within these jurisdictions is whether the state incorporates the therapist's judgment into when the duty is triggered.

- In some jurisdictions, the statute requires therapists to make a determination of whether the patient "has the apparent intent and ability to carry out such a threat" before the therapist's duty to warn/protect the victim is initiated.

- Other jurisdictions, contrarily, impose a duty to warn/protect almost as a functional matter whenever an explicit threat is made

Mandatory/Permissive/No Duty DTP Laws

Permissive States

A second set of jurisdictions permit, but do not require, a therapist to breach the duty of confidentiality to warn/protect a third party of/from the patient's violence. A key variation within this set, however, is how much discretion the statute affords therapists

- On one side of the permissive spectrum, the therapist may disclose a patient's communications. In these states, therapists can breach confidentiality under specified conditions, while also receiving immunity from third party claims when they chose to remain silent.

- On the other side of the spectrum, in some permissive states, although the language of the statutes is permissive, courts there have may have interpreted this permissive language as nevertheless imposing an affirmative duty to warn/protect when the specified conditions are met.

Mandatory/Permissive/No Duty DTP Laws

Ultimately It is Not Easy to Differentiate Between Duty and Permissive States Without Knowing How the Courts in That Jurisdiction Have Interpreted the DTP Statute

Mandatory/Permissive/No Duty DTP Laws

No Law/No Duty States

A few states have either rejected a Tarasoff duty (e.g., North Dakota, North Carolina), or do not have explicit Tarasoff laws (e.g., New York).

In these states, mental health professionals are forced to make judgments about whether to warn/protect potential victims.

These MHPs must attempt to balance their obligation to keep their client's information confidential with the fear of a potential lawsuit from a victim of their patient.

Maryland's Duty to Protect Statute

COURTS & JUDICIAL PROCEEDINGS ARTICLE, §5-609

(b) In general. -- A cause of action or disciplinary action may not arise against any mental health care provider or administrator for failing to predict, warn of, or take precautions to provide protection from a patient's violent behavior unless the mental health care provider or administrator knew of the patient's propensity for violence and the patient indicated to the mental health care provider or administrator, by speech, conduct, or writing, of the patient's intention to inflict imminent physical injury upon a specified victim or group of victims.

Maryland's Duty to Protect Statute (Cont'd)

COURTS & JUDICIAL PROCEEDINGS ARTICLE, §5-609

(c) Duties. --

(1) The duty to take the actions under paragraph (2) of this subsection arises only under the limited circumstances described under subsection (b) of this section.

(2) The duty described under this section is deemed to have been discharged if the mental health care provider or administrator makes reasonable and timely efforts to:

(i) Seek civil commitment of the patient;

(ii) Formulate a diagnostic impression and establish and undertake a documented treatment plan calculated to eliminate the possibility that the patient will carry out the threat; or

(iii) Inform the appropriate law enforcement agency and, if feasible, the specified victim or victims of:

1. The nature of the threat;
2. The identity of the patient making the threat; and
3. The identity of the specified victim or victims

Maryland's Duty to Protect Statute (Cont'd)

COURTS & JUDICIAL PROCEEDINGS ARTICLE, §5-609

(d) Patient confidentiality. -- No cause of action or disciplinary action may arise under any patient confidentiality act against a mental health care provider or administrator for confidences disclosed or not disclosed in good faith to third parties in an effort to discharge a duty arising under this section according to the provisions of subsection (c) of this section

Statutes that Appear to Be DTP Laws But Aren't

Gun-Control Laws

NY's Secure Ammunition And Fire Arm Enforcement (SAFE) Act

IL's Firearm Owners Identification Card Act

What is NOT a DTP Situation

A 3rd Party Who Poses a Serious Risk to the Patient

Challenges in Interpreting DTP laws

- What Does ‘Dangerousness’ Mean?
- Foreseeability Of The Harm Often Involves Difficult Considerations Such As The Ability To Anticipate Future Events Or To Anticipate Dangerous Conditions That Already Exist.
- It Is Extremely Difficult To Accurately Predict Violent Action

Risk Management Approach to DTP Situations

- Know the DTP laws in your jurisdiction
- Good informed consent
- Maintain good working relationship with patient (fosters pt disclosure)
- Assess patient's risk of violence
- Consultation
- Documentation

Limiting Your Exposure to *Tarasoff* Liability

A. Clinical and Legal Education
   1. Know the research literature on violence assessment
   2. Know the laws of your jurisdiction

B. Clinical Information
   1. Obtain past records when they are reasonably available
   2. Read the current record (i.e., the "chart")
   3. Ask the patient about his/her violence history
   4. Ask significant others about the patient's violence history

C. Communication
   1. In sharing the chart with others, communicate information about violence risk

Limiting Your Exposure to *Tarasoff* Liability

Risk Management

1. Make a plan to reduce and manage the patient's risk of violence
   - Incapacitate the patient
   - "Harden the target" of the patient's potential violence
   - Intensify the treatment (increase frequency; add modalities; joint sessions, etc.)

2. Get a second opinion (is evidence of the clinician having met the standard of care)
   - Educational and demonstrates clinician's serious consideration of the risk and of ways of handling it
   - Disadvantages: takes time and may expose the consultant to some risk

3. Follow up on a patient's lack of compliance with treatment

Limiting Your Exposure to *Tarasoff* Liability

ACTION (acronym) (Randy Borum)

- A-attitudes that support or facilitate violence
- Capacity
- T-thresholds crossed
- I-intent
- O-other's reactions
- N-noncompliance with risk reduction interventions.

Limiting Your Exposure to *Tarasoff* Liability

Documentation

Record the source, content and date of all significant information on risk.

Record the content, rationale, and date of all actions to prevent violence.

Limiting Your Exposure to *Tarasoff* Liability

Damage Control

Never falsify a record. It is against the law. You will lose. Better no records or bad records.

Do not confess or admit responsibility or make public statements about the matter.

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Q&A With Dr. Scroppo

- This Q&A will address select questions that were submitted via the Q&A feature throughout the presentation.
- Due to time constraints, we will not be able to address every question asked.